DMR HEALTH CARE RECORD (HCR) INSTRUCTIONS

1. Entry Date: Fill in date HCR is being updated or created
2. Entered by: Fill in name of person updating or creating the HCR
3. Name: Fill name of individual for whom health care record is being updated or created.
4. Likes to be Called: Fill in any names other than what is listed in question #3 that the individual like to be called by.
5. DOB: Fill in date of birth of individual.
6. Gender: Fill in gender of individual, male or female.
7. SSN: Fill Social Security Number of individual
8. Religious Consideration for Care: Fill in individual's religion if known.
9. Street Address 1: Fill in street address of individual
10. Street Address 2: Fill in apartment number or additional street address information if applicable.
11. City: Fill in name of city where individual lives
12. State: Fill in Sate that individual lives in
13. Zip Code: Fill in individual's zip code
14. Phone Number: Fill in individual's phone number at home
15. Primary Health Insurance: Fill in name of primary health insurance
16. Primary Health Insurance ID Number: Fill in Primary Health Insurance ID number
17. Secondary Health Insurance: Fill in name of secondary health insurance if any.
18. Secondary Health Insurance ID Number: Fill in ID number to secondary health insurance if any.
19. Agency Responsible for Providing Residential Services: Answer Yes or No.
20. If Yes, Name of Agency: If answer to question #19 is "Yes" fill in name of Residential Provider.

21. If Yes, Primary Contact Person: If answer to question #19 is Yes, fill in name of primary contact person at agency.

22. If Yes Phone Number: If answer to question #19 is Yes, fill in phone number of contact person listed in question #21

23. Consent Status: Select an option.

24. If Consent from Guardian, Name: Fill in name of guardian

25. If Consent from Guardian, Phone Number: Fill in phone number of guardian

26. Resuscitation Status: Select an option.

27. If DNR, Is Comfort care Form Available?: Fill in Yes, No, or Unknown

28. Health Care Proxy?: Answer Yes, No or Unknown

29. If Yes, Name: If Yes to #28, fill in name of health care proxy

30. If Yes, Phone Number: If Yes to #28, fill in phone number of health care proxy

31. Contact Information Type: Choose type of contact: Emergency Contact or Pharmacy

32. Name: Fill in name of contact person from #31

33. Street Address #1: Fill in street address of contact named in #31

34. Street Address #2: Fill in additional street address from #31 if applicable

35. City: Fill in city for address named in #31

36. State: Fill in state for address in #31

37. Zip: Fill in zip code for address in #31

38. Phone Number: Fill in phone number for contact named in #31

31-38: Repeat questions #31 through #38 for other contact listed (Emergency contact, Pharmacy)

39. Medication Name: Fill in name of medication (repeat by filling in all medications ordered)

40. Reason for Prescription: Select from Dictionary #1 (repeat for each medication listed)

41. If other, please specify: If there is no appropriate option for a medication that is listed in #39, and "other" was chosen in #40, please fill in reason for prescription.

42. Frequency: Choose from Dictionary #2 for each medication listed under #39

43. Date Started: List date medication was started under #46 using MM/DD/YYYY format

44. Date Stopped: Fill in date medication was stopped for each medication listed under #39 using MM/DD/YYYY format

Repeat #39-#44 for other medications.

45. Type of Allergy: Select from options all that apply

46. To What: Fill in what specifically the individual is allergic to if #52 indicates an allergy exists

47. Type of Reaction: Fill in what allergic reaction looks like if #52 indicates an allergy exists

CURRENT PROBLEMS/DIAGNOSES

48. Neurologic Medical Problem/Diagnosis: Select all that apply

49. If other, please specify: If "other" chosen in #48, fill in diagnosis

50. Cardiovascular Medical Problem/Diagnosis: Select all that apply

51. If other, please specify: If "other" chosen in #50, fill in diagnosis

52. Respiratory Medical Problem/Diagnosis: Select all that apply

53. If other, please specify: If "other" chosen in #52, fill in diagnosis

54. Gastrointestinal Medical Problem/Diagnosis: Select all that apply

55. If other, please specify: If "other" chosen in #54, fill in diagnosis

56. Musculoskeletal Medical Problem/Diagnosis: Select all that apply

57. If other, please specify: If "other" chosen in #56, fill in diagnosis

58. Kidney/Urinary Medical Problem/Diagnosis: Select all that apply

59. If other, please specify: If "other" chosen in #58, fill in diagnosis

60. Cancer/Neoplasm Medical Problem/Diagnosis: Select all that apply

61. If other, please specify: If "other" chosen in #60, fill in diagnosis

62. Metabolic/Endocrine Medical Problem/Diagnosis: Select all that apply

63. If other, please specify: If "other" chosen in #62, fill in diagnosis

64. Syndromes Medical Problem/Diagnosis: Select all that apply

64.A. If other, please specify: If "other" chosen in #64, fill in diagnosis

65. General Medical Problem/Diagnosis: Write in any diagnosis that did not appear in any of the previous categories

66. Psychiatric Problem/Diagnosis: Select all that apply

67. If other, please specify: If "other" chosen in #66, fill in diagnosis

68. Communication: Select all that apply

69. If foreign language, please specify: Write in language individual speaks/understands if language is not English

70. Vision: Select from the options

71. Supportive Devices: Select all that apply

71A. If other, please specify: If "other" chosen in #71, write in supportive device

72. Hearing: Select from the options

73. Toileting Ability: Select all that apply

74. Medication Administration: Select from the options

75. Dining/Eating: Select all that apply

75A. If other, please specify: If "other" chosen in #75, write in dining/eating needs

76. Diet Texture: Select all that apply

77. Diet Type: Write in the type of diet

78. Ambulation: Select all that apply

78A. If requires wheelchair, owns own wheelchair? Fill in Yes, No or Unknown

78B. If owns own wheelchair, when was it acquired? If answer to #78A is Yes, write in date wheelchair was received

79. Other type of ambulation? Fill in Yes, No or Unknown

80. If other type of ambulation, please specify: If answer to #79 is Yes, fill in type of ambulation

81. Personal Hygiene: Select one

81A. If special needs, please specify: If answer to #81 was special needs, write in description of needs

82. Oral Hygiene: Select one

82A. If special needs, please specify: If answer to #82 was special needs, write in description of needs

83. Head of bed elevated: Answer Yes, No or Unknown

84. Any previous problems with anesthesia? Answer Yes, No or Unknown

85. If yes, please explain: If answer to #84 is Yes, explain problem

86. Usual response to medical/dental/exams: Select one

87. Sedation for clinical visits: Answer Yes, No or Unknown regarding whether or not sedation is needed for medical or dental visits

88. If yes, what type of clinical visit? If answer to #87 is Yes, explain type of medical/dental visit requires sedation

89. If yes, please explain the type of sedation used: If answer to #87 is Yes, explain type of sedation used

90. Special positioning required for examination: Answer Yes, No or Unknown

91. If yes, please explain: If answer to #90 is Yes, explain type of special positioning required

92. Double staffing required for assistance with exams: Answer Yes, No or Unknown

93. If yes, please explain: If answer to #92 is Yes, explain why double staffing is needed

94. Requires limited waiting periods for exams: Answer Yes, No or Unknown

95. Appointment schedule preference: Select all that apply

96. Special communication device/method: Answer Yes, No or Unknown

97. If yes, please explain: If answer to #96 is Yes, explain type of communication device or method

98. Pain response: Select one

99. If unique, please explain: If answer to #98 is Unique, please explain

Fill the following **Medical Providers** as indicated:

100. Contact: Healthcare Provider Type: Primary Care
100A Name 100B Address 100C City 100D State 100E ZIP 100F Telephone

101. Contact: Healthcare Provider Type: Dental Care
101A Name 101B Address 101C City 101D State 101E ZIP 101F Telephone

102. Contact: Healthcare Provider Type: Eye Care
102A Name 102B Address 102C City 102D State 102 E ZIP 102 F Telephone

103. Contact: Subspecialist Type: Pull From Dictionary #3
103A Name 103B Address 103C City 103DState 103E ZIP 103F Telephone

104. Contact: Subspecialist Type: Pull from Dictionary #3
104A Name 104B Address 104C City 104D State 104E ZIP 104F Telephone

105. Contact: Other Type: Fill in here
105A Name 105B Address 105C City 105D State 105E ZIP 105F Telephone

106. Living status: Select one

107. Marital status: Select one

108. Work/Day program status: Select all that apply

109. Current Nursing Supports: Select all that apply

110. Tetanus status? Select one

111. Date of most recent tetanus: If answer to #110 is "Administered" fill in date of last tetanus administration using DD/MM/YYY format

112. Flu shot status? Select one

113. Date of most recent Flu shot: If answer to #112 is "Administered" fill in date of most recent administration using MM/DD/YYYY format

114. Pneumovax status? Select one

115. Date of most recent Pneumovax: If answer to #114 is "Administered" fill in date of most recent administration using MM/DD/YYYY format

116. Hepatitis B vaccine – Primary Series (3 shots) status? Select one

117. Date of Shot #1 (MM/DD/YYYY): Fill in date of 1st shot in hepatitis B series if answer to #116 is "Administered"

118. Date of Shot #2 (MM/DD/YYYY: If known fill in date of 2nd shot in hepatitis B series if answer to #116 is "Administered"

119. Date of Shot #3 (MM/DD/YYYY: If known fill in date of 3rd shot in hepatitis B series if answer to #116 is "Administered"

120. Hepatitis B vaccine booster status? Select answer

121. Date of most recent Hepatitis B vaccine booster (MM/DD/YYYY): If known fill in date of 3rd shot in hepatitis B booster vaccine using MM/DD/YYY format if answer to #120 is "Administered"

122. Measles/Mumps/Rubella (MMR) status? Select one

123. Date of most recent Measles/Mumps/Rubella (MMR): If known fill in date of most recent MMR if answer to #122 is "Administered"

124. List any other vaccinations and dates (e.g., Lyme, Hepatitis A, Varicella, etc.): Write in types of vaccinations and dates administered if known

125. Has the individual ever had a positive skin test (PPD) for tuberculosis? Answer Yes, No or Unknown

126. If yes, was any treatment given? Answer Yes, No or Unknown if answer to #125 is Yes

126A. If Yes, please describe.
126B. If No, please explain why treatment was not given: Write explanation if answer to #125 is No

127. Is the date of the last PPD known? Answer Yes or No

127A. If Yes, date of last PPD: If answer to #127 is Yes, fill in date if known using MM/DD/YYYY format
127B. If No, please explain: If answer to #127 is No, please write in explanation

PAST MEDICAL HISTORY

128. Medical History Contact Name: If medical history is not released to DMR, fill in name of person who is to be contacted if such information is needed by HCPS

129. Relation: Fill in relation type of person written in #128

130. Phone number: Phone number of person listed under #128

131. Street Address #2: Additional street address information for person listed under #128 if needed

132. City: City address of person listed under #128

133. State: State address of person listed under #128

134. Zip: Zip code of person listed under #128

135. Surgeries and Trauma; Hospitalization; Type of Event: Select all that apply

136. If hospitalization, which hospital? Fill in name of hospital for event(s) listed under #135

137. Description: Fill in description of event(s) listed under #157 (e.g., fell, broke leg)

138. Date: Enter date(s) of event(s) listed under #135 using MM/DD/YYYY format

139. Age menstruation stared (women only): Select an age

140. Still menstruating? Answer Yes, No or Unknown

141. If no, age menstruation stopped: If answer to #140 is No, choose an age

142. Has individual ever given birth to a child? Answer Yes, No or Unknown

143. Gynecological exam status? Select one

144. Date of last gynecological exam: Fill in date if answer to #143 is "Administered" using MM/DD/YYY format

145. PAP smear status? Select one

146. Date of last PAP smear: Fill in date if answer to #145 is "Administered" using MM/DD/YYY format

147. Any history of abnormal PAP smear? Answer No or Yes, if yes - describe

148. Mammogram status? Select one

149. Date of last mammogram? Fill in date if answer to #148 is "Administered" using MM/DD/YYY format

150. Neurologic Medical Problem/Diagnosis: Select all that apply

151. If other, please specify: If "other" chosen in #150, fill in diagnosis

152. Cardiovascular Medical Problem/Diagnosis: Select all that apply

153. If other, please specify: If "other" chosen in #152, fill in diagnosis

154. Respiratory Medical Problem/Diagnosis: Select all that apply

155. If other, please specify: If "other" chosen in #154, fill in diagnosis

156. Gastrointestinal Medical Problem/Diagnosis: Select all that apply

157. If other, please specify: If "other" chosen in #156, fill in diagnosis

158. Musculoskeletal Medical Problem/Diagnosis: Select all that apply

159. If other, please specify: If "other" chosen in #158, fill in diagnosis

160. Kidney/Urinary Medical Problem/Diagnosis: Select all that apply

161. If other, please specify: If "other" chosen in #160, fill in diagnosis

162. Cancer/Neoplasm Medical Problem/Diagnosis: Select all that apply

163. If other, please specify: If "other" chosen in #162, fill in diagnosis

164. Metabolic/Endocrine Medical Problem/Diagnosis: Select all that apply

165. If other, please specify: If "other" chosen in #164, fill in diagnosis

166. Syndromes Medical Problem/Diagnosis: Select all that apply

167. If other, please specify: If "other" chosen in #166, fill in diagnosis

168. Psychiatric Problem/Diagnosis: Select all that apply

169. If other, please specify: If "other" chosen in #168, fill in diagnosis

170. General Medical Problem/Diagnosis: Write in any diagnosis that did not appear in any of the previous categories

EVALUATION TYPE

171A. Audiological Exam
171B. Is Evaluation Date available?
171C. Yes and date fill in date using MM/DD/YYY format
171D. No
17IE. If No, explain why

172. Eye Exam – Repeat as with #171A – 171E
173. Dental Exam – Repeat as with #171A – 171E
174. Physical Exam – Repeat as with #171A – 171E

175. Bone Densitometry – Repeat as with #171A – 171E
176. Sigmoidoscopy/Colonoscopy – Repeat as with #171A – 171E
177. Prostate Screening (PSA) – Repeat as with #171A- 171E

FAMILY HISTORY

178. Relationship: Select one

178A. Is this family member known? Answer Yes or No

178B. If Yes, is the family member deceased? If answer to #178A is Yes, answer Yes, No or Unknown
178C. If deceased, age at death: If answer to #178B is Yes, fill in age at death if known
178D. If deceased, cause of death: If answer to #178B is Yes, fill in cause of death if known
178E. If not deceased, year of birth: If answer to #178B is No, fill in year of birth if known

179 - 181. Repeat questions for other family members listed

182. Is there any family history of: Diabetes? Fill in Yes, No or Unknown

183. Is there any family history of: High Blood Pressure? Fill in Yes, No or Unknown

184. Is there any family history of: High Cholesterol? Fill in Yes, No or Unknown

185. Is there any family history of: Heart Disease? Fill in Yes, No or Unknown

186. Is there any family history of: Osteoporosis? Fill in Yes, No or Unknown

187. Is there any family history of: Colon Polyps? Fill in Yes, No or Unknown

188. Is there any family history of: Cancer? Fill in Yes, No or Unknown

189. If Cancer, what type? If answer to #188 is Yes, fill in type

190. Are there any other diseases that run in the family? Fill in Yes, No or Unknown. If Yes, please specify:

191. Has there been any genetic counseling in the family? Fill in Yes, No or Unknown. If yes, what were the results of genetic counseling